CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(A2) MC	LTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION		A. BUIL	DING	00	COMPL	
		150065	B. WINC	G		08/03/2	011
NAME OF PROVIDER OR SUPPLIER				411 W T	ADDRESS, CITY, STATE, ZIP CODE		
SCHNEC	K MEDICAL CENTE	ER		SEYMO	DUR, IN47274		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR 1	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
S0000							
	This visit was for	a State licensure survey.	S00	000			
	Facility #: 00506	60					
	Survey Dates: 08	3-1/03-11					
	Surveyors:						
	Billie Jo Fritch, F Public Health Nu						
	Jennifer Hembree Public Health Nu						
	Ken Zeigler Laboratorian						
	QA: claughlin 08	8/17/11					
S0554	410 IAC 15-1.5-2(a) (a) The hospital sh			•			
	and healthful envir minimizes infectior to patients, health visitors.	onment that n exposure and risk	S04	554	S554 Cleaning of the vagina	al	09/01/2011
	and interview, the				probe will occur per manufac s guidelines. The Cleaning, Handling, Disposal, and Stor	cture'	33,101,2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CC	NSTRUCTION	(X3) DATE				
			A. BUI	LDING	00	COMPL			
		150065	B. WIN			08/03/2	011		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE				
COUNT	OK MEDICAL CENT	TD			TIPTON ST				
	CK MEDICAL CENT				/MOUR, IN47274				
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX TAG	I '	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE		
IAG		he risk of infection	+	IAG	of Patient Care Equipment a	nd	DAIL		
	1				Supplies Policy and Procedu				
	exposure to patie	ents.		and The Reusable Items,					
	Eindings in sluds				Guidelines for Cleaning Police				
	Findings include	··			and Procedure were updated 8/23/11 to reflect manufactur				
	1 While towning	the medial corruptmes ound			cleaning guidelines. A High L				
	1	g the radiology ultrasound			Disinfectant Quality Assurance				
	1 ^	-2-11 at 1110 hours with			Sheet will be implemented to				
	· ·	erved that Sporicide			monitor the effectiveness of the high level disinfectant. A wall				
	1 *	g used to disinfect the			mounted G Ultrasound Soak				
	intracavity (vaginal) ultrasound probes.				station for the cleaning was				
	2. While touring the obstetrics department on 8-2-11 at 1250 hours with #S6 and #S25, it was observed that Virus Tb was used to disinfect the intracavity (vaginal) ultrasound probes. 3. Review of facility policy titled Cleaning, Handling, Disposal, and Storage of Patient Care Equipment and				installed on 9/1/11 for cleaning				
					the ultrasound vaginal probe Staff from Obstetrics was	S.			
					educated on the process cha	inge			
					on 8/25/11 and Diagnostic				
					Imaging educated on 8/25/11	l.			
					The Director of Diagnostic	200			
					Imaging will monitor compliation a weekly basis.	rice			
	1				,				
		es the following on page 3 itical - These items are							
	1								
	1 "	ome in contact with							
	mucous membrane or with skin that is not intact. These items must be free of all microorganisms, with the exception of high numbers of bacterial spores. Intact								
	1 -	-							
		ne are generally resistant							
	1	ommon bacterial spores,							
	_	ble to other organisms, bacilli and viruses.							
	1								
	These items requ	_							
	disinfection with								
	1 -	chemical germicides							
	such as glutarald								
	4. Review of the	e manufacturer's							

005060

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150065	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/03/2011	
NAME OF PROVIDER OR GURN UP			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				411 W 7	TIPTON ST		
SCHNE	CK MEDICAL CENT	ER		SEYMC	OUR, IN47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X:	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	!	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE	DAT	E
	recommendations from General Electric provided by #S22 on 8-3-11 for						
	1 ^	intracavity (vaginal)					
		the following high level					
	1 -	ents have been approved					
	1	probes: Cidex OPA,					
	_	us, Sporox II High Level					
	· ·	ra Safe High Level					
	· ·	erBacBle, Sani-Cloth HB					
	· ·	Γ-spray II, and Virus II					
	256.	1 3 7					
	5. Review of the Virex TB instructions on						
	8-2-11 indicates the following: If on skin						
	or clothing, rinse	e skin immediately with					
	soap and water.	Review of the Sporicide					
	wipes on 8-2-11	indicates the following:					
	Wash thoroughly	with soap and water					
	after handling.						
	6. Interview wit	h #S25 on 8-2-11 at 1250					
	hours indicates t	he intracavity probes used					
	in OB are cover	red with a condom for					
	1 -	the procedure, the					
		ved, the probe is sprayed					
	with Virus TB, allowed to remain wet for						
	10 minutes, and						
		h #S22 on 8-2-11 at 1520					
		he intracavity probes are					
		idiology ultrasound					
	1 1	a condom for patient use;					
	_	ire, the condom is					
	_	bbe is wiped with a					
		and then wrapped in a					
		for 10 minutes; the probe					
	is not washed to	llowing the removal of					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIF	PLE CON		(X3) DATE S COMPL			
AND FLAN	OF CORRECTION	150065		A. BUILDING 08/03/2011				
			B. WING _	REET AI	DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				IPTON ST			
	K MEDICAL CENTI		SE	EYMO	UR, IN47274			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE		
1110			111				DATE	
	the Sporicide wipe; #S22 indicates the intracavity probes are considered							
		ipment because they						
	•	ontact with patient						
		ne if the condom were to						
	tear.	ne ii tiie condom were to						
		h #S23 on 8-3-11 at 1010						
		ne facility policy for						
		rity (vaginal) probes does						
	_	cility practice or the						
		ecommendations for						
	cleaning intracav	rity probes; #S23						
	confirms the intra							
	considered semic							
	could come in co							
	mucous membrai	ne if the condom tore						
	during the proceed	dure.						
S1118	410 IAC 15-1.5-8 ((b)(2)						
	(b) The condition of	of the physical						
	plant and the over							
	environment shall	-						
	safety and well-be	n a manner that the ing of patients are						
	assured as follows							
	(2) No condition s	hall be created or						
	maintained which							
	hazard to patients	, public, or						
	employees.	ation and intomious 41-	S1118	.	S1118 The eye wash station in	the	08/31/2011	
		ation and interview, the condition that could	51118	'	boiler room was installed on 8/3		08/31/2011	
	result in a hazard				in the area where water testing i			
	resuit iii a iiazaiu	to facility staff.			done with the use of caustic	_		
					chemicals. Plant Operations staf	I		

SULIDING Name of PROVIDER OR SUPPLIER SCHNECK MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON STA	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
NAME OF PROVIDER OR SUPPLIER SCHNECK MEDICAL CENTER SCHNECK MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG FREGULATORY OR LSC IDENTIFYING INFORMATION) Findings: I While touring the facility on 8-2-11 at 1050 hours with #S16 - #S20, it was observed that there was no eye wash in the boiler room area where water testing is done with the use of caustic chemicals. 2. Interview with #S16 and #S19 on 8-2-11 at 1050 hours confirm there is not an eye wash available in the area where water testing is done in the boiler room using caustic chemicals and that the nearest eye wash would be very difficult to reach if there were a chemical splash in the eyes. S1168 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on document review and observation, the facility failed to ensure defibrillators were checked according to manufacturers guidelines for 6 units. ST168 STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN47274 ID PREFIX TAG PROFICATION TAG PREFIX TAG PREFIX TAG PROFICATION TAG PREFIX TAG PROFICATION TAG PREFIX TAG PROFICATION TAG PROFICATION TAG PROFICATION TAG PROFICAT	ANDILAN	or correction		1 ' '		00	COMPLETED 08/03/2011	
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1050 hours with #816 - #820, it was observed that there was no eye wash in the boiler room area where water testing is done with the use of caustic chemicals. 2. Interview with #816 and #819 on 8-2-11 at 1050 hours confirm there is not an eye wash available in the area where water testing is done in the boiler room using caustic chemicals and that the nearest eye wash would be very difficult to reach if there were a chemical splash in the eyes. S1168 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on document review and observation, the facility failed to ensure defibrillators were checked according to manufacturers guidelines for 6 units. S1168 S116 The Operator Shift Checklist for the "M" series Zoll Defibrillator will be implemented in patient care areas and checked per shift per manufacturer's guidelines. An e-mail was sent to		ringings.						
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manufacturers guidelines for 6 units. per shift per manufacturer's guidelines. An e-mail was sent to		defibrillators wer	-					
all numbers at affect and other metions		manufacturers gu	uidelines for 6 units.					
care units on 8/29/11 explaining the process change. Changes will		Findings include			gu all ca	all nursing staff and other pacare units on 8/29/11 explain	tient iing	
1. Manufacturers guidelines for the Zoll also be discussed at Nurse			_					
M series defibrillator states on page 106: Practice Council and Unit Base Council at the September		M series defibrill	lator states on page 106:				se	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER: 150065	(X2) MULTIPLE CC	00 	COMP.	LETED
		150000	B. WING	ADDRESS SITE STATE SITE OF		<u> </u>
NAME OF PROVIDER OR SUPPLIER			l l	ADDRESS, CITY, STATE, ZIP COI TIPTON ST	DE	
	CK MEDICAL CENT	ER	l l	DUR, IN47274		_
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	"Recommended be performed at a The recommended included, but was Defibrillator Mu connected to test energy level to 3 button; "TEST O Recorder." 2. During tour of 10:00 a.m. on 8/2 defibrillators were defibrillators were defibrillators obstacility is checking daily basis. The	checks and procedures to the start of each shift." ed checks and procedures s not limited to, "C alti-function cable connector: Set defib 0 joules, press SHOCK	TAG	meeting. The manage patient care area will e compliance is met. Thi change will be monitor Director of Critical Car on a monthly basis.	r of each ensure is process red by the	DATE